

DENTAL INFILTRATE INFORMED CONSENT

I _____ understand that a Dental Infiltrate will be performed to provide temporary relief of discomfort associated with the administration of Restylane®. I understand that Dental Infiltrates are not 100% effective but should reduce pain in most cases.

The risks of a Dental Infiltrate include bleeding, infection, and adverse reaction to the anesthetic.

_____(Initial) I do not have any hypersensitivity to any local anesthetic agents, nor do I have a history of malignant hyperthermia.

I have read and understand this consent and all of my questions have been addressed and answered to my satisfaction. I have no contraindicating factors, and thereby grant permission for a Dental Infiltrate. I certify that if any changes occur in my medical history/health or regime, that I will notify the physician or nurse practitioner who is treating me.

Patient Name (*print*): _____

Signature: _____

Witness: _____

Date: _____

Steven Tidwell, M.D./Heidi Garguilo, ARNP-BC